Standards for Public Health In Washington State: Baseline Evaluation Report

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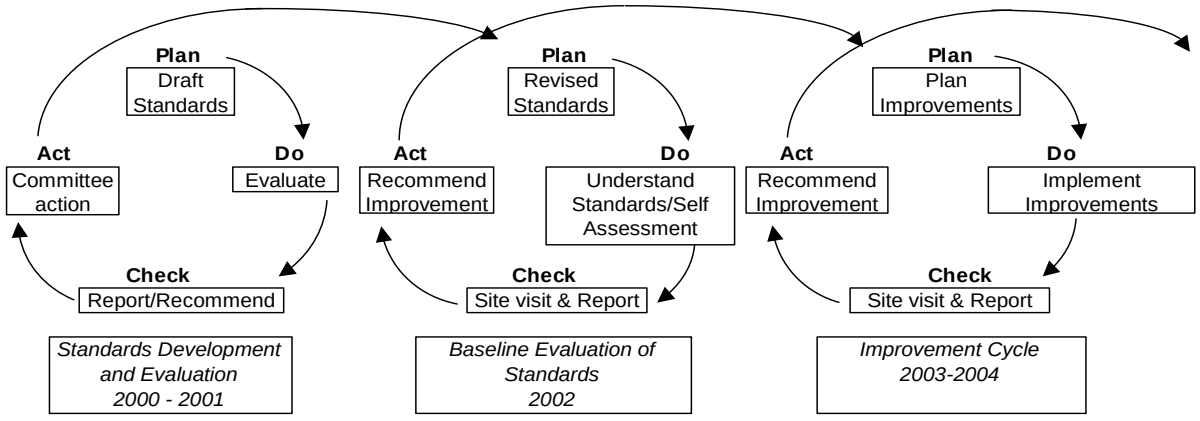
Executive Summary

The Standards

The Standards for Public Health in Washington State were developed through a collaborative effort between state and local health officials. Over the course of several years, more than 150 individuals participated in meetings, workshops and review sessions, resulting in publication of the Standards in 2000, their evaluation through on-site review, and subsequent revision and adoption as of June 2001. This report summarizes the first baseline evaluation of Washington State local health jurisdictions and Department of Health programs against the Revised Standards.

As noted in the 2000 report of the evaluation of the Standards, the process itself uses the Quality Improvement Shewhart cycle: the Revised Standards are the *Plan* step; the self evaluations are the *Do* step; the site visits, data analysis and this report are the *Check* step; and the future work on system improvement will be the *Act* step. The following diagram summarizes the present and future application of the Shewhart cycle to the standards.



The Baseline Evaluation Process

The baseline evaluation included all 34 local health jurisdictions (LHJs) in the state and 38 Department of Health (DOH) program sites selected by the DOH for evaluation. Each site was asked to complete a self-assessment tool regarding the standards and their measures and to prepare for the on-site evaluation by organizing the documentation that demonstrated the standards and measures. An independent consultant reviewed the documentation and scored each measure. This document review and scoring was used for quantitative evaluation. In addition, potential exemplary practice documentation was collected from each site. The on-site

reviews concluded with an exit interview in which qualitative information regarding supports necessary to demonstrate performance and feedback on the Standards was obtained. This "snapshot" of the system was conducted in DOH programs during June 2002 and in LHJs during August and September 2002; improvement to these findings is already underway, based on the learning in preparing for the site reviews and in the exit conferences.

Overall Findings

Current Statewide Performance

In considering overall system performance, it was observed that it is very difficult for any single part of the public health system to fully appreciate the enormous scope of all the activity at DOH and within LHJs. While the Standards are a partnership project between DOH and LHJs, with standards set for the system as a whole and measures separately defined for DOH and LHJs, there is a large body of work performed by DOH that is not seen by and does not directly involve LHJs. This work, however, is also included in the standards review, and many examples were provided of work with other system stakeholders and local entities.

Similarly, most DOH/LHJ joint activity is focused programmatically, leading to limited information on the part of DOH staff about the full scope of work conducted by LHJs. Some LHJs are consolidated Health and Human Services Departments, with major contracting relationships with DSHS and other state and local programs; some LHJs have significant contracting relationships with the Department of Ecology and other entities related to Environmental Health activities. Local LHJ general fund support varies, Environmental Health relies substantially on fee-generated revenues, and there is no substantive state or local earmarked revenue base (minimally addressed by MVET replacement, which is threatened) for many of the functions addressed by the Standards such as Assessment and Communicable Disease. Thus, the examples brought forward by LHJs came from their full scope of work, not just those programs contracted through DOH.

It was also clear that, to the extent that flexible funding exists (e.g., local capacity development funds), there have been differing priorities among LHJs. Some of the very best examples collected, such as intensive assessment activity and community involvement in priority setting, detailed environmental health education materials and classes, or well developed water quality protocols, came into being because of targeted funding, either local capacity development funds or local/regional funding sources.

In light of these points, in considering overall system performance, it cannot be emphasized enough that the scoring was based on the best examples the sites had to offer. In many instances in the LHJs, these examples came from contracted program areas where the planning, evaluation and reporting mechanisms are very specific, and some resources are provided for the quality management of the program as well as the direct delivery of the services. While it demonstrates that sites know how to do the work, it cannot be assumed that they have the staff capacity and resources to replicate their best examples in other areas of activity.

With these caveats, observations regarding overall system performance include:

- The system works as well as it does because of the skills and commitment of the staff and the scope and depth of work being done to improve the health status of the public.

- The strengths of the system are tied to investments that have been made over the last ten years, including: local capacity development funds, which have been used for focused efforts within LHJs; a focus on public involvement and community partnerships; and a focus on developing assessment capacity and products within DOH and LHJs.
- The site reviewers observed that improvements had been implemented and documented in the last two years since the Standards Evaluation process.
- Many state and local processes are person dependent, as they rely extensively on a "rich oral tradition" and the assumption that "everyone knows" what their respective roles are, the right person to contact, or how to complete a task
- Certain areas of performance are strong throughout the system—notably in the topic areas Standards for Public Health Assessment (reflecting a system-wide initiative from the mid 1990s), Standards for Communicable Disease and Other Health Risks, and Standards for Prevention and Community Health Promotion.
- Certain areas of performance are weaker throughout the system—in the topic areas Standards for Environmental Health and Standards for Access to Critical Health Services.
- In the key management practices, the system performs well on Public Information and Community Involvement (again, reflecting system-wide initiatives during the 1990s), with considerable variation in the other six key management practices (Governance Process; Policies, Procedures and Protocols; Program Plans, Goals, Objectives and Evaluation; Key Indicators; Workforce Development; Quality Improvement).
- There is a positive correlation between the size of local jurisdiction budget and/or number of employees and the likelihood of demonstrated performance on roughly a quarter of the measures.
- Having a budget level of $7 million and/or 70 FTEs is predictive of being in the group of LHJs that demonstrated performance on more than 60% of the measures.
- There is also variability among LHJs that is not connected to budget or size. Some small town/rural LHJs demonstrated higher overall performance than some urban LHJs. Of the group of LHJs demonstrating performance on more than 60% of the measures, 27 % were non-urban LHJs with budgets around $2 million and less than 30 FTEs. What may be predictive of their performance is that each of them demonstrated more than 70% of the assessment measures (higher than all but one of their non-urban peers), as well as demonstrating more than 70% performance in one other topic area.
- This variability indicates that performance, while connected to budget and size, also has other drivers. Field observation suggests these may include: local priority setting; leadership; local funding; staff skill, training, and experience; and, documentation and data systems.
- The dilemma for most sites is that the "doing" of the work takes precedence over the documentation of the work; however, the standards and measures focus not only on doing the work but on the quality improvement steps of planning, implementation of changes, and evaluation of the work.

Findings Specific to the Standards and Their Measures

The Standards for Public Health in Washington State are organized into five topic areas. Within each of these five topic areas, four to five standards are identified for the entire governmental public health system. For each standard, specific measures are described for local health jurisdictions and, separately, for the state Department of Health and its programs. It is

important to remember that the topic areas are not synonymous with programs. For example, all of the measures that address public information and media relations are found under the Communicable Disease topic area, but are applicable across the system; similarly, all of the measures related to emergency planning and response are found under the Environmental Health topic area, but are applicable across the system.

Findings are reported separately for LHJs and state programs and summarized in the topic area charts at the end of this executive summary. These charts restate the standards referenced below. Charts that show measure level performance for each Standard are found in Attachment B of the full report.

In the summary analysis that follows, there is a focus on the 50th percentile, in which the midpoint is envisioned as a fulcrum: where the weight falls toward demonstrated performance, fine tuning may be needed, but the system is heading in the right direction; and, where the weight falls towards no or partially demonstrated performance, these areas will require significant planning and assistance to achieve compliance.

Understanding Health Issues: Standards for Public Health Assessment

LHJ Demonstration

- 15 of 24 measures (63%) in this topic area have at least 50% of LHJs demonstrating performance
- For Standards 1, 2 & 3 most all of the measures (80%) had at least 50%or more of LHJs demonstrating performance
- For Standards 4 and 5 most of the measures (60 to 75%) had less than 50% of LHJs demonstrating performance

DOH Demonstration

- 21 of 22 measures (95%) in this topic area have at least 50% of applicable state programs demonstrating performance
- All Standards have more than 70% of programs demonstrating performance across all of these measures

Protecting People from Disease: Standards for Communicable Disease and Other Health Risks

LHJ Demonstration

- 16 of 26 measures (62%) in this topic area have at least 50% of LHJs demonstrating performance
- For Standard 2, 100% of the measures were demonstrated by 50% or more of LHJs
- For Standard 3, one third of the measures were demonstrated by 15% or less of LHJs
- For Standard 5 the average demonstration by LHJs was 39% and two-thirds of the measures for this standard were demonstrated by 50% or less of LHJs

DOH Demonstration

- 20 of 26 measures (77%) in this topic area have at least 50% of applicable state programs demonstrating performance
- In three measures, none of the applicable state programs were able to fully demonstrate performance: 1.5.4, *goals, objectives and measures for communicable disease*, 3.5.3, *annual evaluation of communicable disease investigation*, and 4.5.4, *communication issues during outbreaks are addressed*

Assuring a Safe, Healthy Environment for People: Standards for Assuring a Safe, Healthy Environment for People

LHJ Demonstration

- 9 out of 18 measures (50%) in this topic area have at least 50% of LHJs demonstrating performance
- 9 of the measures were only met by 30% or less of LHJs, sometimes as low as 6%

DOH Demonstration

- 12 of out 20 (60%) measures in this topic area have at least 50% of applicable state programs demonstrating performance
- For Standard 1, only half of the measures had performance demonstrated by 50% or more of the applicable state programs
- For Standard 3, three out of five measures had less than 50% demonstration by applicable state programs
- For two measures, no applicable program fully demonstrated performance: 1.6.5, *education plan identifies performance measures for education programs*, and measure 3.8.3, *development of a quality improvement plan*

Prevention is Best/Promoting Healthy Living: Standards for Prevention and Community Health Promotion

LHJ Demonstration

- 12 out of 19 measures (63%) in this topic area have at least 50% of LHJs demonstrating performance
- For Standard 3, only two of five measures demonstrated performance by 50% or more of LHJs
- For Standard 5, two of four measures had 20% or less of LHJs demonstrating performance

DOH Demonstration

- 16 out of 23 measures (70%) in this topic area have at least 50% of applicable state programs demonstrating performance
- For Standard 4, more than half of the measures had less than 50% demonstration by applicable programs
- Measure 2.7.5, *training in community mobilization methods*, was not demonstrated by any applicable program

Helping People Get the Services They Need: Standards for Access to Critical Health Services

LHJ Demonstration

- 5 of 11 measures (45%) in this topic area have at least 50% of LHJs demonstrating performance
- For Standard 2, no measures had at least 50% of LHJs demonstrating performance
- For Standard 4, both measures had less than 20% of LHJs demonstrating performance

DOH Demonstration

- 8 out of 13 (62%) measures in this topic area have at least 50% of applicable state programs demonstrating performance
- No applicable programs demonstrated measures 1.6.1, *information provided to LHJs about provider availability*, and 2.7.4, *studies regarding workforce needs*

Findings Related to Key Management Practices

Chart 6 at the end of this executive summary provides an overview of performance on measures, organized by key management practices, which cut across all topic areas and standards. The system overall performs very well in the key management practices of Public Information and Community and Stakeholder Involvement, reflecting an effort on the part of the system over the last ten years to improve in these areas. There is considerable variation in the other key management practices.

- LHJs are able to fully demonstrate measures relating to policies and procedures, or planning and evaluation in less than 40% of LHJ sites, while better than 50% of DOH programs are able to fully demonstrate these measures.
- Less than half of LHJ sites can fully demonstrate key indicators to measure and track, while almost 60% of DOH programs are able to do so, largely due to the recent production of The Health of Washington report.
- While LHJs are better able than DOH programs to document staff training efforts, as the recommendations discussion regarding training needs indicates, this often reflects just one person who has been trained.
- LHJs have few examples of quality or process improvement activities—these were fully demonstrated in just 20% of sites, and notably, there was no demonstration in over 50% of LHJ sites. DOH programs were better able to fully demonstrate process improvement activities—these, however, were programmatic and not part of any overall improvement approach within DOH. Review of the detailed charts show that DOH performance on the measures related to quality was strongest in the Assessment area, and variable across the other topic areas.

Other key management practice findings, based on the detailed charts, include:

- Local BOH involvement is least demonstrated in regard to the Access measures, with just 22% of LHJs able to fully demonstrate BOH involvement.
- Measures relating to policies and procedures in the Environmental Health topic area are fully demonstrated in only 16% of LHJs and 30% of DOH programs.
- LHJs can fully demonstrate measures relating to policies and procedures in the Assessment topic area in only 28% of sites, and in the Prevention topic area, 24% of sites.
- Program planning and evaluation measures are fully demonstrated by LHJs in the Communicable Disease topic area by only 19% of sites, and in the Environmental Health topic area, by 23% of sites. Similarly, DOH programs fully demonstrate program planning and evaluation measures for Communicable Disease in only 30% of programs and in Environmental Health, 29% of programs.

Recommendations

The recommended actions fall into three areas: the supports and resources needed to fully demonstrate the standards and measures, clarification and refinement of the Standards themselves, and the future process for integrating the Standards into the system and sustaining the review process**.**

Supports Needed to Improve Performance

- *Financing and Staff*
  Funding levels are at the top of everyone's list. DOH programs prioritized more and flexible funding as the major support needed, and more staff to accomplish the work envisioned in the standards. LHJ sites also gave top priority to the need for more funding and staff, as well as flexibility in funding. Currently, state or federal programmatic funding drives the ability to deliver most programs at the local level, regardless of established priorities, especially in the smaller jurisdictions. There is little room for flexibility, and there is minimal earmarked state or local funding for some of the basic work of public health as outlined in the Standards, such as Assessment, Communicable Disease and Environmental Health. The site reviews captured the performance of the system as it faces further funding reductions, which challenged even the optimists about how to maintain current performance, much less improve on it.

- *Specific Staff Skills*
  Many DOH and LHJ leaders described the need to find public health staff that can come to the job prepared to do the work. Develop a Human Resources plan that describes professional requirements for an effective health education and promotion staff whether employed by DOH or LHJs, and create recruitment strategies for the system. Similarly, skills in assessment, epidemiology, analysis and program evaluation were mentioned frequently by DOH and LHJ sites; these skills can be especially difficult to find in non-urban jurisdictions and would benefit from a system-wide recruitment approach.

- *Program Planning Processes*
  There is a significant opportunity to reduce administrative demands on LHJs while supporting the development of infrastructure that is consistent for all programs and incorporating the standards into the everyday work of DOH programs and LHJs. Develop model templates (content requirements and format) for project applications, worksheets, program proposals, measurement, program evaluation and reporting that are consistent with and address the Standards and specific measures. To the extent possible (e.g., within the constraints of federal or other funding requirements), adopt the model templates in all DOH programs that contract with LHJs for services.

- *Standard State Databases*
  Standardize databases for clinical services, environmental health, and communicable disease tracking, and use the same data base throughout the local health jurisdictions; standardize systems for data collection, data gathering, and data analysis, including a surveillance system to receive, record, and report on environmental health indicators throughout the state.

- *Standard Key Indicators To Track*
  Over the long term, performance on the Standards should be paired with a consistent set of indicators that provide numeric measurement and benchmarks. There is a strong sense that this work needs to be done statewide, not locally or program by program. DOH should lead a process, along with local assessment coordinators, to develop a simplified approach to standard key indicators (using the Florida model of a brief summary report rather than lengthy narrative descriptions).

- *BOH/Community Involvement*
  One of the strengths of the public health system in Washington is the extent of the community partnerships that have been built at both the state and local levels. This was observed throughout the site visit process. On the other hand, the involvement of local Boards of Health varies considerably; this is especially true relative to the review of data and the linkage between data and health policy. This suggests the development of statewide strategies to strengthen local BOH processes.

- *DOH Consultation and Standard Templates, including Policies and Procedures*
  As with the discussion above regarding key indicators, there is considerable interest in developing model templates that can be adopted throughout the state. While RCWs and WACs provide the legal framework for some programs, there is a need to more clearly spell out in policy or protocol the "what" and "how" and "who" of daily implementation. Consider developing templates for: the basic components of environmental health education; environmental health protocols for investigation and reporting; communicable disease protocols for investigation and reporting: evaluation/self-audit processes for communicable disease and environmental health investigation and outbreak/event management and debriefing; procedures to develop, distribute, evaluate, and update health education and promotion information; and confidentiality policies.

- *Documentation Methods and Information Technology Systems*
  Create the ongoing and institutionalized measurement processes at the state level that are necessary to support LHJs in prioritizing community mobilization regarding critical health services access. Build on the work by the State Board of Health in regard to critical health services (list of services adopted September 2000) and measurement of access to critical health services by creating a report that is a companion to the Health of Washington report (which currently has some components of access tracking)—Indicators of Health Access in Washington.

- *QI/Program Evaluation Skills*
  DOH and LHJ sites indicated that development of skills in the areas of quality/process improvement and program evaluation were needed. In the site reviews, the measures that looked for training or skills in these areas found very few people system-wide. In addition to assuring that training is available, develop and disseminate a model process or template for doing process improvement in a cost efficient manner for use by both LHJs and DOH programs.

- *Role Clarity*
  There continues to be considerable lack of clarity and discomfort with the roles envisioned for both DOH and LHJs in regard to Access to Critical Health Services—even while there is agreement that the healthcare delivery system is in trouble and that access issues for the uninsured have been joined by access issues for Medicaid, Medicare, and in some instances, insured individuals.

  In addition to working on role clarification in Access, develop DOH internal policies regarding roles and responsibilities for programs that address disease outbreaks,

specifically describing the roles among Communicable Disease, Environmental Health and other DOH program areas (e.g., Immunization) and clarify respective roles regarding interaction with LHJs.

- *Training*
  Training should be developed and offered periodically in each of the content areas identified in the key management practice of workforce development, across all topic areas. Specifically, the staff skills and capacity to do quality improvement, program evaluation, community mobilization and health education and promotion have to be developed in addition to skills in providing traditional public health services. Regularly available training should also be available on the core functions of public health—this training was offered during a time of transition, but there are always new people coming into the system who don't have this knowledge base. Both DOH and the LHJs have work to do in consistently training staff regarding confidentiality and data security, as well as on risk communication and emergency response plans.

Revisions to the Standards

There were no significant changes mentioned by site participants in regard to the topic areas or the standards themselves, although "fine tuning" was mentioned for some topic areas, such as Environmental Health. Because this has been a baseline evaluation, it is important to keep the current version of the Standards as stable as possible through the next cycle of site visits. Consequently, topic areas and standards should remain as written. Minor revisions to clarify measures are summarized in Attachment F.

Sustaining the Standards Process

The leadership of the DOH, of LHJs and Boards of Health must embrace and consistently reinforce the message of the standards—*performance and health indicator data form the foundation for establishing health policy and measuring and improving the public health system.*

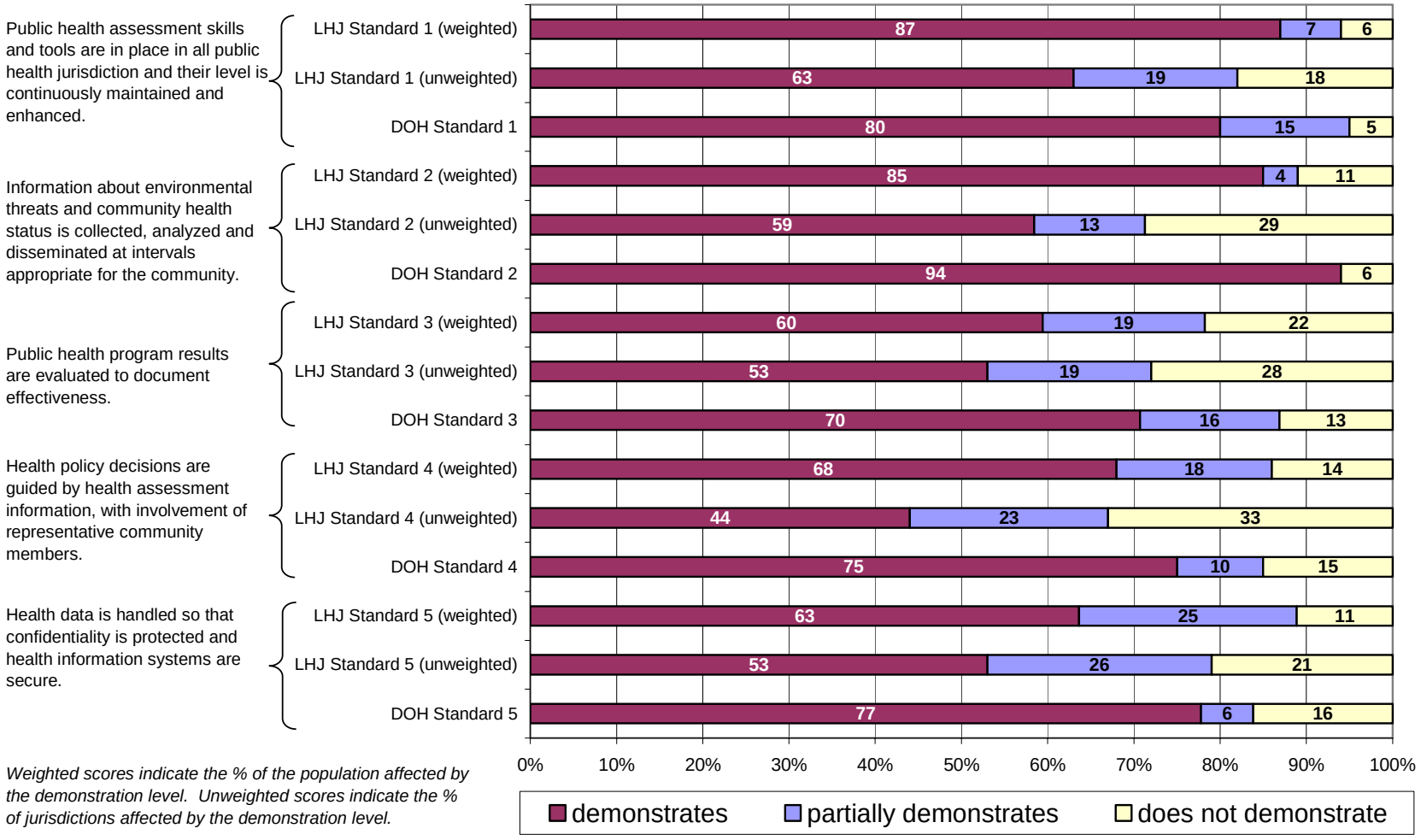
It is necessary that a critical mass of managers and staff are familiar with the standards in order to integrate the philosophy and principles of standards for performance measurement into the culture of the public health system. Orientation to the standards and to the basic principles of performance measurement should be included in the DOH general orientation curriculum and in the specific DOH program and LHJ orientation processes. Assure that another round of training in basic standards and preparing for the site visit is provided in the months before the next cycle of site reviews. Communicate to DOH programs and LHJs that it is essential to send the person(s) who will actually be preparing the materials for the site review—in many instances, the people who actually did the work were not at the trainings and were lacking the information they needed to do the work they were assigned.

The single most consistent piece of feedback about the process is that the timing was terrible, coming as it did during the vacation and budget season. If the site review process were adjusted to occur in the second quarter of the calendar year, the results would be more usefully incorporated into budgets as well as causing less conflict with vacation schedules. The implication of shifting the timing is that the next cycle would occur in either less than two years or at about 2 ¾ years from the just completed site visits. In light of the considerable effort

required of the system to prepare for site visits, the longer cycle is recommended for the next time, to be followed by a more stable two-year cycle.

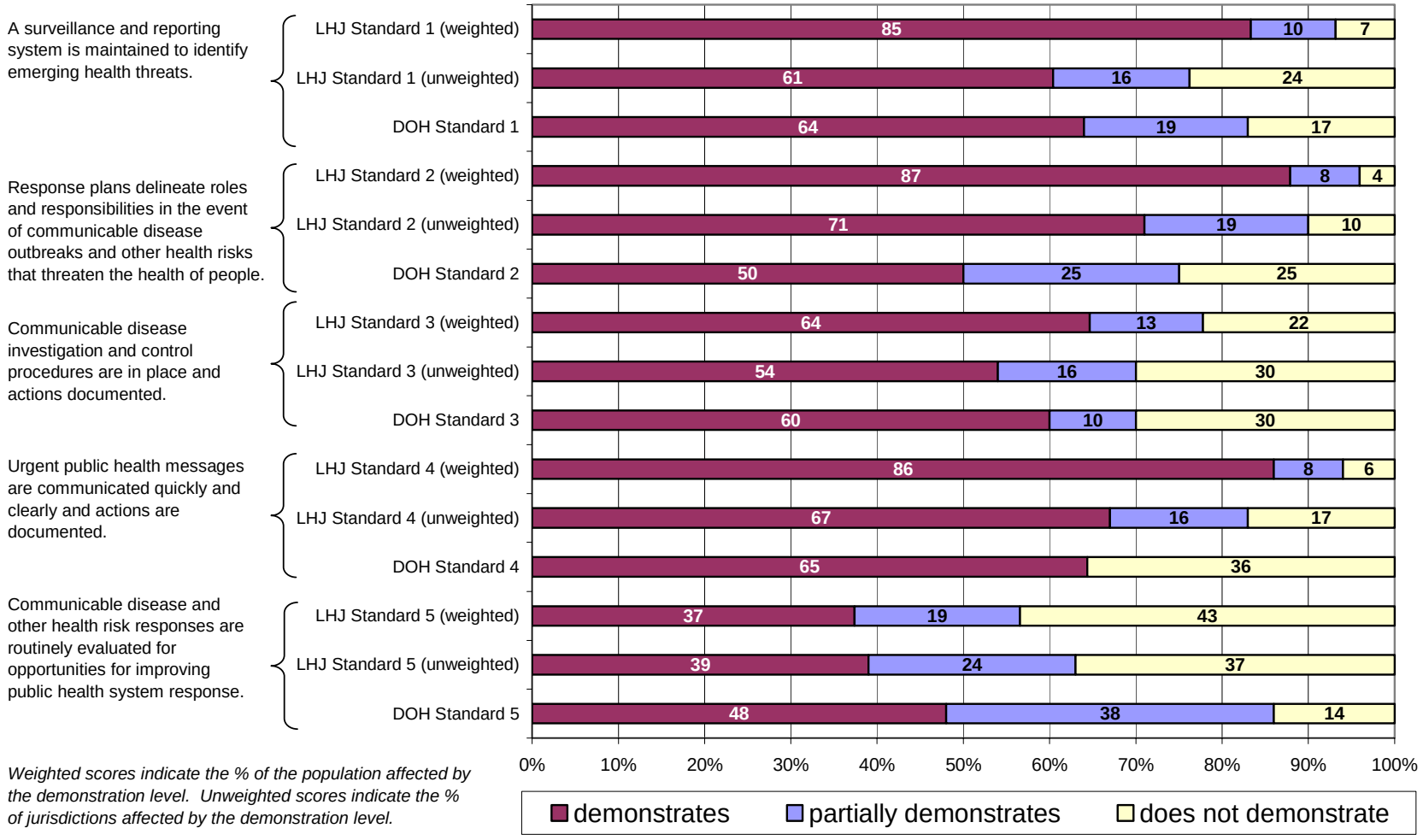
These findings and recommendations should be utilized to determine next steps in the Public Health Improvement Plan (PHIP), leading to the next generation of work on performance management in the Washington State public health system.

Chart 1: Understanding Health Issues - Demonstration Levels of LHJs (weighted and unweighted) and DOH Programs



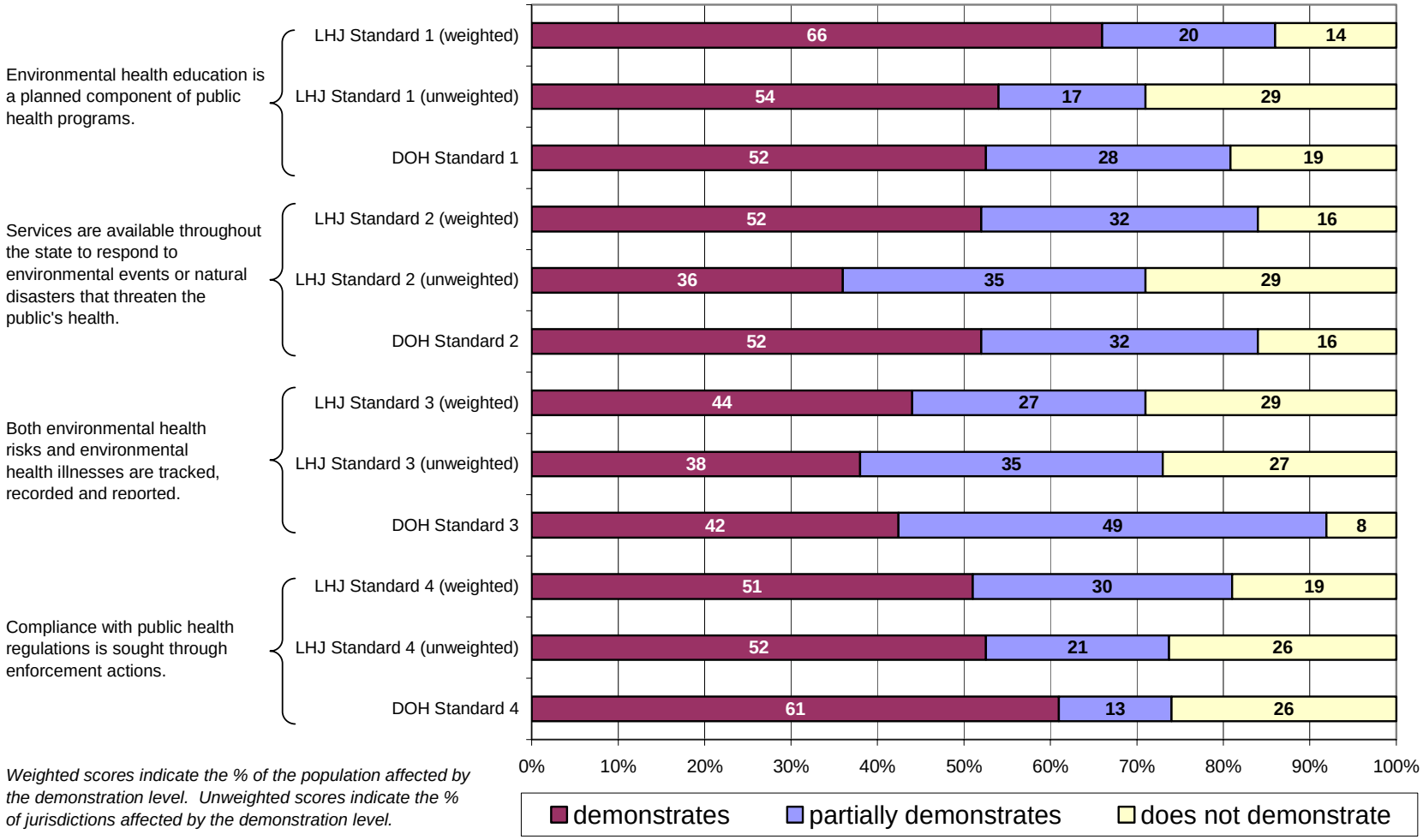
Weighted scores indicate the % of the population affected by the demonstration level. Unweighted scores indicate the % of jurisdictions affected by the demonstration level.

Chart 2: Protecting People from Disease - Demonstration Levels of LHJs (weighted and unweighted) and DOH Programs



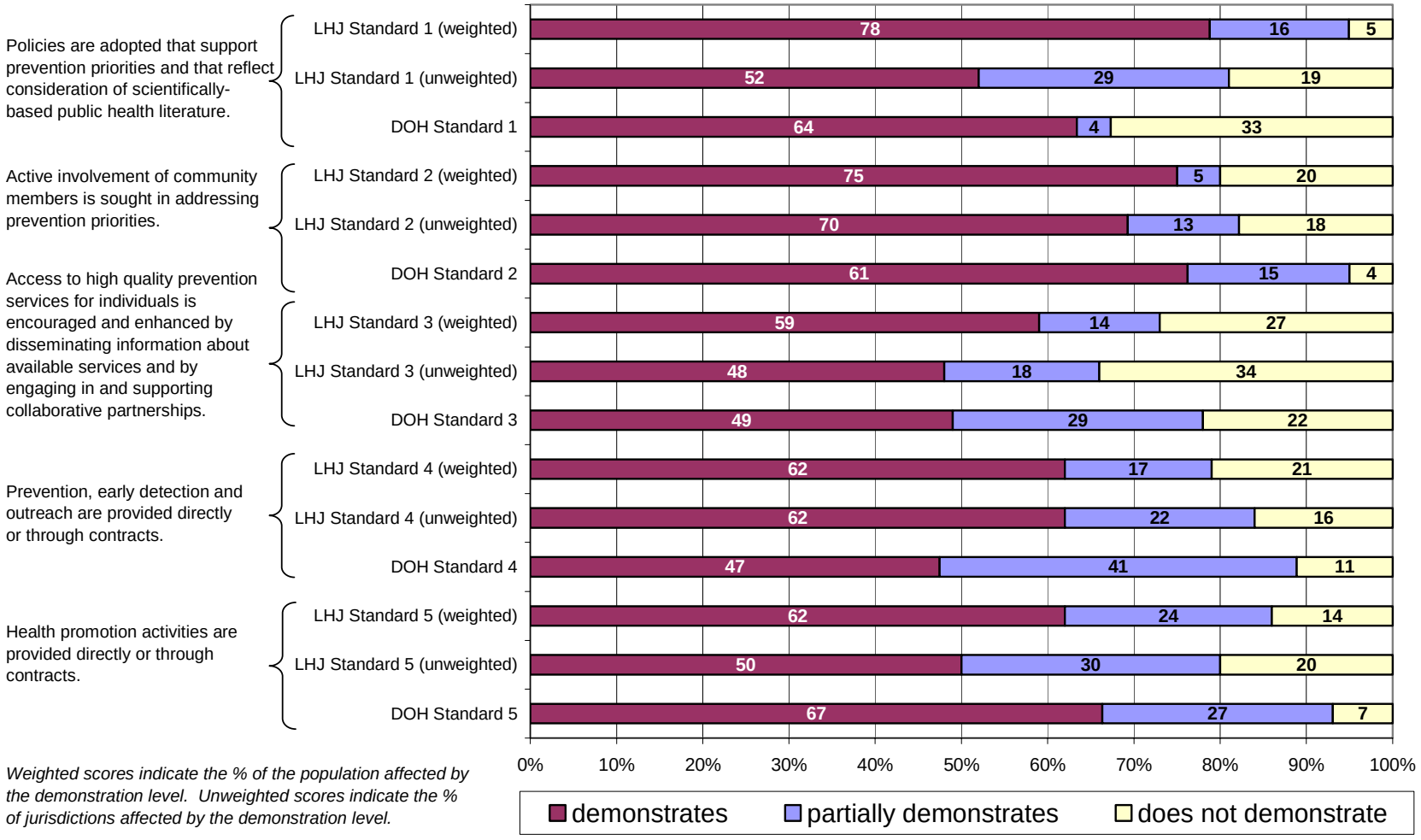
Weighted scores indicate the % of the population affected by the demonstration level. Unweighted scores indicate the % of jurisdictions affected by the demonstration level.

Chart 3: Assuring a Safe, Healthy Environment for People - Demonstration Levels of LHJs (weighted and unweighted) and DOH Programs



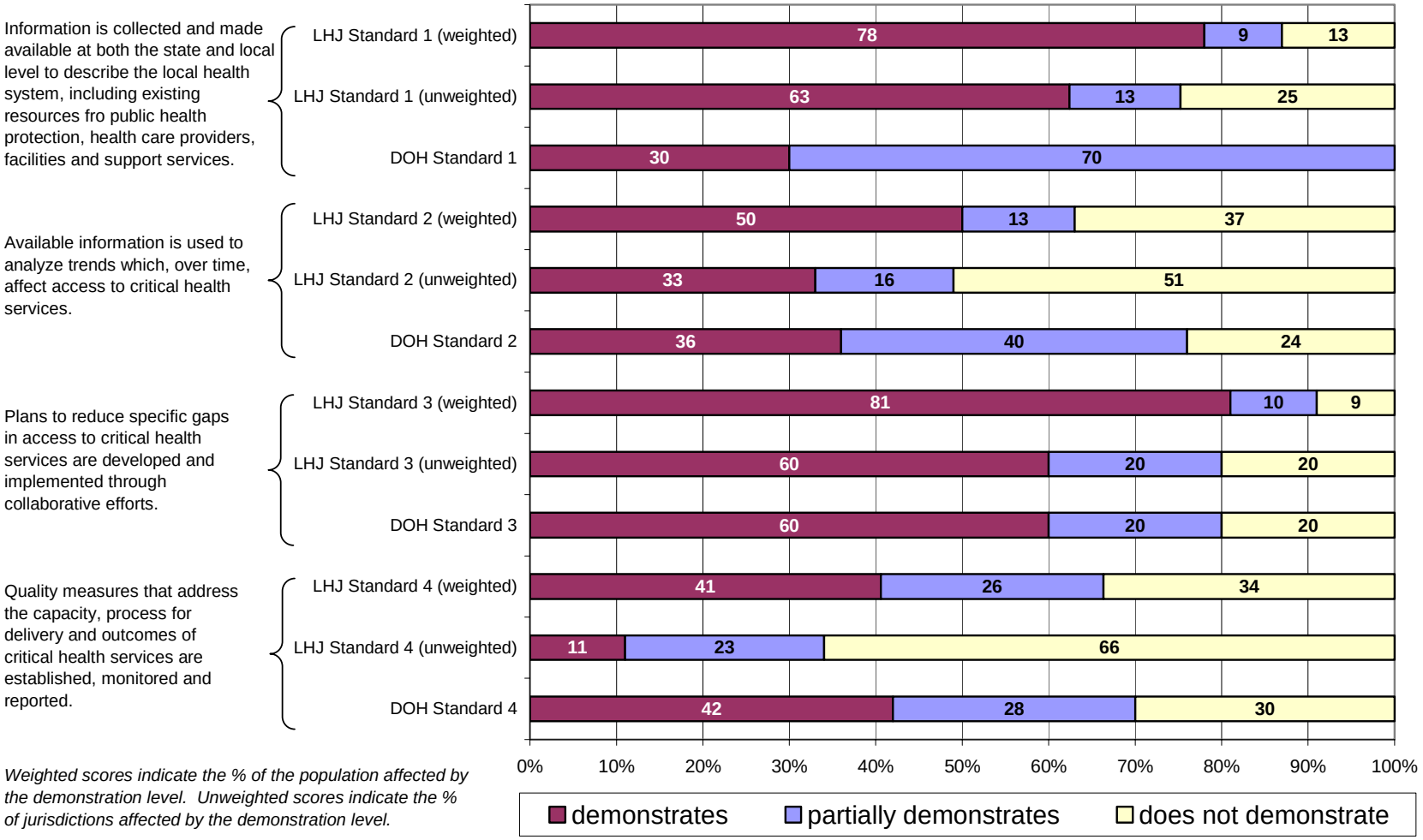
Weighted scores indicate the % of the population affected by the demonstration level. Unweighted scores indicate the % of jurisdictions affected by the demonstration level.

Chart 4: Prevention is the Best: Promoting Healthy Living - Demonstation Levels of LHJs (weighted and unweighted) and DOH Programs



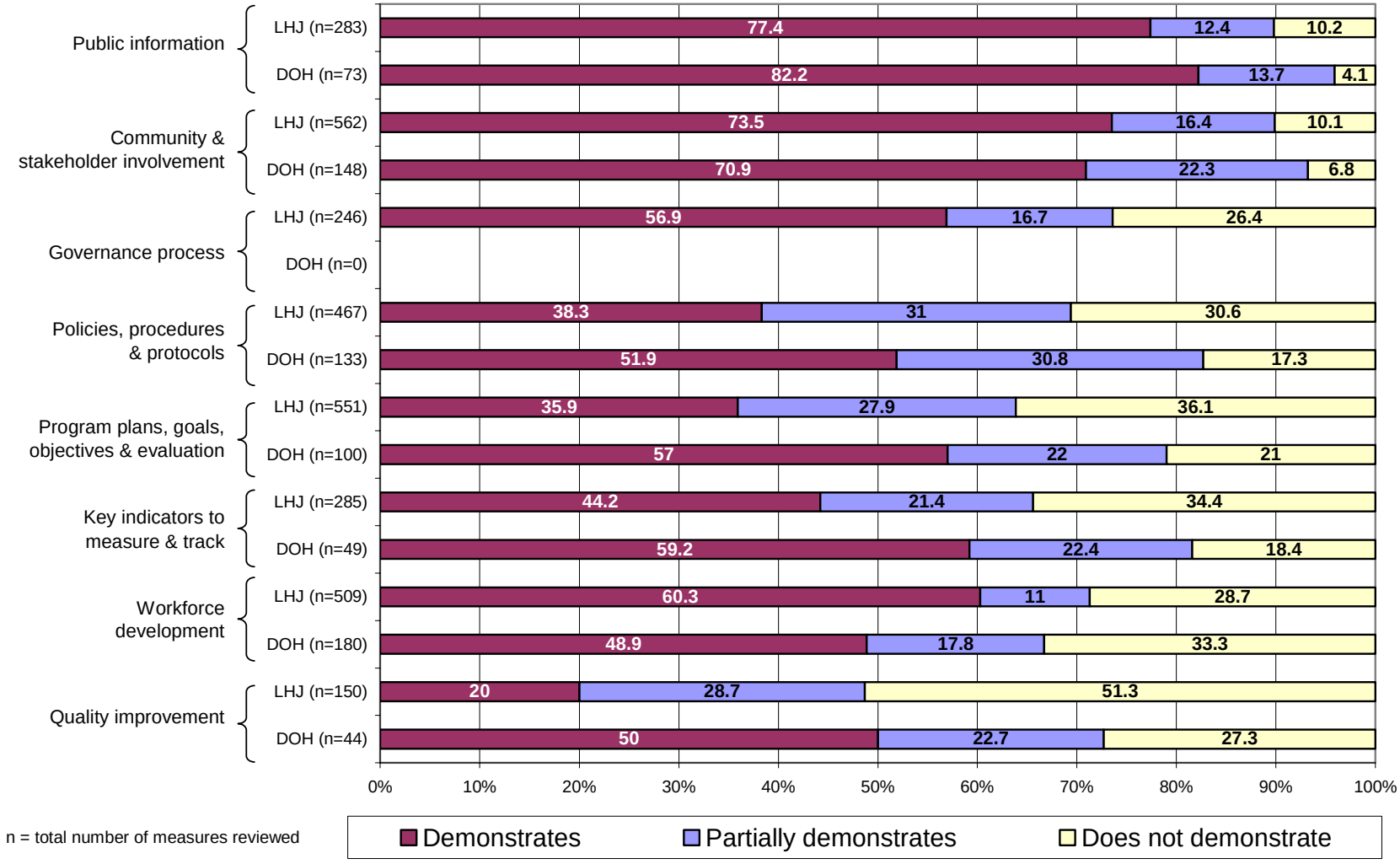
Weighted scores indicate the % of the population affected by the demonstration level. Unweighted scores indicate the % of jurisdictions affected by the demonstration level.

Chart 5: Helping People Get the Services They Need - Demonstration Levels of LHJs (weighted and unweighted) and DOH Programs



Weighted scores indicate the % of the population affected by the demonstration level. Unweighted scores indicate the % of jurisdictions affected by the demonstration level.

Chart 6: - Standards Demonstration of LHJ and DOH Programs by Key Management Practice Areas



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